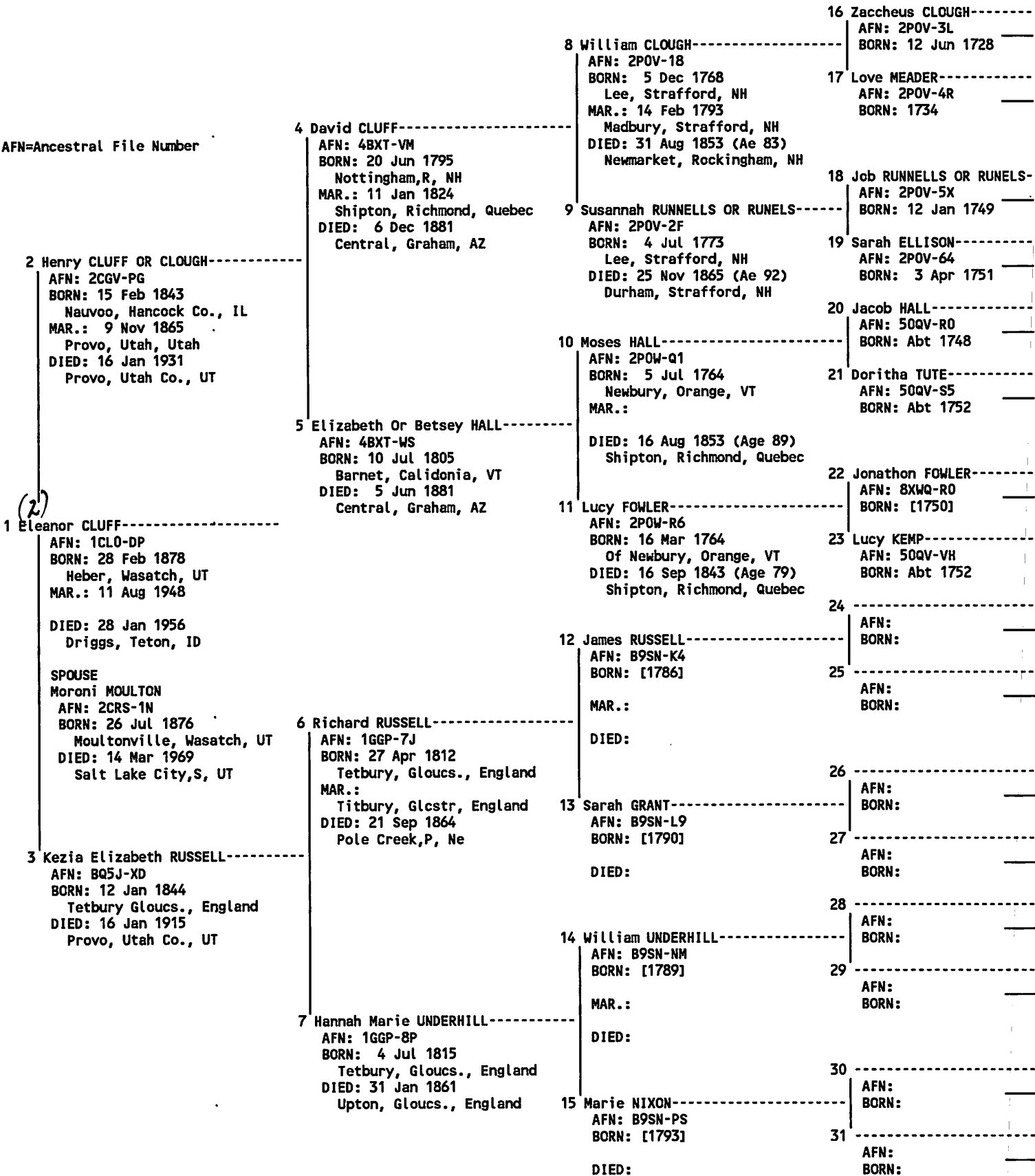


No. 1 on this chart is the same as no. _____ on chart no. _____

AFN=Ancestral File Number



7. NATURAL CAUSE OF DEATH, ILLNESS, INJURY DIAGNOSIS OR MEDICAL CALL IF INJURY, HOW AND WHERE DID ACCIDENT HAPPEN	
8. NAME OF SPOUSE	NAME AND ADDRESS OF SPOUSE'S EMPLOYER (IF NOT EMPLOYED WRITE "NOT EMPLOYED")
9. ARE YOU OR YOUR DEPENDENT COVERED UNDER ANY OTHER GROUP INSURANCE, HEALTH MAINTENANCE ORGANIZATION, OR GOVERNMENT PLAN WHICH WILL ALSO PAY FOR ANY OF THE MEDICAL EXPENSES OF THIS CLAIM? <input type="checkbox"/> YES, <input type="checkbox"/> NO. IF YES, GIVE NAME, ADDRESS & POLICY NUMBER OF INSURANCE COMPANY PROVIDING BENEFITS.	
NAME AND ADDRESS	
POLICY NO	
10. IF PAYMENT IS TO BE MADE TO PHYSICIAN SIGN BELOW	11. PATIENT OR PARENT MUST SIGN BELOW
AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the undersigned Physician, otherwise payable to me for his services as described below, but not to exceed the reasonable and customary charge for those services.	
SIGNED (COVERED PERSON) SIGN ONLY IF PAYMENT IS TO GO TO DOCTOR	
AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any Licensed Physician, Medical Practitioner, Hospital, Clinic or other medical or medically related facility, insurance company or institution or person, that has any records or knowledge of my health to release that information to United Businessmens Insurance Trust. A photocopy of this authorization shall be as valid as the original.	
SIGNED	